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SYPHILIS OF THE ENDOME-
TRIUM.

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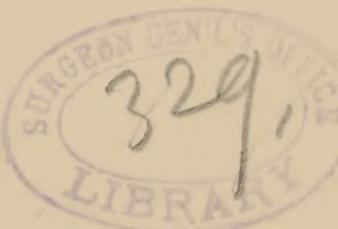


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SYPHILIS OF THE ENDOME- TRIUM.

There are few, if any, of the organs or tissues of the body which are not involved in one way or another in the various manifestations of syphilis, when once the virus of this malady becomes a constitutional infection.

That the syphilitic poison has predilections for certain organs and tissues is a well-known fact. The manifestations of this disease are largely influenced by bodily conditions and constitutional states. Thus anæmia, chlorosis and general debility favor the outbreak of syphilitic lesions which might have pursued a milder course, or been kept in total abeyance, by a condition of health. Pregnancy is supposed to exercise the same influence upon the syphilitic woman. The character of this influence is modified largely by the age of the syphilis. Thus a woman who contracts syphilis during pregnancy is affected differently from one who contracts the disease prior to conception. In the first case the predisposition to premature delivery is far less potent than in the second.



Secondary syphilis is almost sure to manifest itself in the syphilitic woman when the disease is contracted prior to conception or during the act of conception. Ohlshausen mentions that among 657 syphilitic women, 231 miscarried, while 426 were delivered at term of living and dead children. Parvin states that at Lourcine 260 aborted out of 416 pregnant syphilitic women.

Abortions induced through syphilitic influence may be brought about either through maternal or foetal infection. A woman previously inoculated with syphilis will abort more readily than one who contracts the disease during pregnancy, and the danger of abortion seems to be in ratio to the period of infection. Thus contagion communicated at the time of fecundation is more likely to lead to a separation than where the poison has been introduced after the fourth month. Syphilis may be communicated through the father to the foetus, which may or may not result in its death and separation, and the mother may escape infection. On the other hand mothers have become infected through the foetus. A woman may have secondary syphilis and pass through the entire term of pregnancy without any manifestation of the disease in connection with the reproductive organs, but this condition of ex-

emption may be regarded as an exception to the general rule that syphilitic women are almost sure to abort.

When pregnancy becomes established in the syphilitic subject it invites a manifestation of the disease at the point of contact of the foetal and maternal tissues. The decidua may become involved in a condition known as *syphiloma of the decidua* and the placenta may be so modified in its structure and mode of development as to constitute a condition recognized as placental syphilis. The extent of these changes which take place in the decidua and placenta indicates the result of the syphilitic involvement. Separation may or may not occur according to the extent and influence of the poison upon the maternal and foetal tissues. The placenta may be affected throughout its entire thickness, or only either the maternal or the foetal portion. When the infection occurs through the mother, the maternal portion is that which is chiefly involved and *vice versa* when the disease approaches through the foetus.

The local manifestation of the syphilitic virus in the decidua, as a general rule, to which I know of only two exceptions, ceases as soon as separation takes place, whether by miscarriage or labor at full term. The degenerative

changes which follow the termination of gestation seem sufficient to remove the involved endometrium. This process must almost invariably take place. I have been unable to find any references in the literature of this subject to a continuation of the syphilitic manifestation upon the endometrium after labor or miscarriage. If observers have noted this condition they have been singularly remiss in calling attention to it. That a condition of continued involvement of the mucous membrane at the placental site does occur, my experience with two cases herein related fully confirms.

The condition observed is one of continued proliferation of epithelial tissue—a highly luxuriant granulation, if I may so term it—which returns again and again after removal, resembling in this respect the proliferative exfoliations of an epithelial cancer. The sole origin of this condition I have referred to secondary manifestations of syphilis in the endometrium at the placental site or in this neighborhood. The disease under consideration has followed, in the two cases under my own observation, a miscarriage which was referred to the influence of the syphilitic poison. In case two there was a return of the endometrial trouble, after an interval of

three years, from date of former treatment, which could have no reference to any other known causative influence. In my opinion syphilis was the entire cause of an inflammatory condition of the endometrium which was followed by hyperplasia of the elements of the decidua, a condition which has been described by De Sinéty as a fibroid degeneration of the villi of maternal syphilitic origin. Why the latent influence of the syphilitic virus should have manifested itself in endometrial involvement I am unable to explain any more than the various other singular anomalies of this disease, which do not seem susceptible of rational solution. We can the more readily understand the primary outbreak of secondary syphilis in the decidua and placenta during gestation and the continuation of the syphilitic influence upon the endometrium after miscarriage, since here we have the possible retention of placental tissue as a probable nidus for the subsequent outgrowth of granulations. In this instance the influence of the poison is simply continued until overcome by local and constitutional treatment.

The subsequent development of syphilitic lesions upon the endometrium I can only account for upon the general assumption of a local dyscrasia in con-

nection with the lining membrane of the uterus inviting a concentration of the specific influence upon this membrane which resulted in hypertrophy of the glandular elements and a degenerative change in the epithelial lining of the uterine cavity.

In case one, in which the local influence was continued after the separation of the foetus, the lesions were localized, that is, in seeming relation with the placental site. In case two, the entire lining membrane of the cavity seemed involved though the process in this case was more tractable to treatment than in case one.

I present the histories of these cases.

Mrs. A., aged 24 years, primipara, miscarried between the fifth and sixth months of pregnancy. Prior to this event she had been treated by her attending physician for an indurated chancre and subsequent mucous patches on her vulva and labia minora. This disease she had contracted from her husband during the early weeks of married life. She was not informed as to the nature of the affection and has been kept in ignorance of the specific character of her trouble out of deference to her domestic relations. Following the miscarriage, a portion of the afterbirth was retained, but this was speedily re-

moved with the curette. Hæmorrhage, however, continued for some five or six weeks, and during this time the curette had been employed two or three times, each time removing lumps of degenerated mucous membrane and vegetations. The uterus remained large, subinvoluted, and in a very relaxed condition, and as a result of frequent intra-uterine applications and curetting, a mild metritis was induced, which was followed by elevation of temperature, violent pain and profuse muco-purulent discharge more or less tinged with blood. Recognizing the specific history of this patient the family physician made use of anti-syphilitic treatment with almost negative results. Mrs. A. continued to run down and by copious losses of blood was greatly reduced in flesh and strength. Her physician losing confidence in his own intelligent treatment of the case requested me to see the patient in consultation, and then insisted upon my taking entire charge of the case. The diagnosis, already established, was confirmed and an effort was made to relieve the distressing symptoms, which at this time were referable to the constant and profuse hæmorrhage, subinvolution, uterine colic and general debility. Ergot, which had previously been administered, was again employed

The uterine cavity was carefully curetted and large masses of epithelial tissue and vegetating fungosities were removed. Astringent applications, iodoform, tannin and other agents designed to influence the tissues through local effect, were employed. The result of this method was temporary in its effect. Hæmorrhage would cease for a few days, but the least bodily exercise would cause its reappearance. The granular condition of the endometrium would again and again reappear after constant curetting, employed at intervals of one or two weeks. The tendency to a re-formation or outgrowth of fungous neoplasms was so constant that it was next to impossible to suppress them for a longer time than a few days. In addition to the local treatment, which was heroic enough to answer every temporary purpose, ergot and iodide of potash and general tonics were administered thrice daily, in large doses. Mercury had been employed by my predecessor and I simply gave the iodide of potash. This condition of the endometrium continued off and on for over three months during which time I employed the curette frequently and made constant applications to the endometrial surface. Finally the tendency to proliferation of fungous tissue began to diminish and I had the

pleasure of witnessing a gradual shrinkage in the size of the uterus, a contraction of its walls and returning healthy condition of the endometrium. The menorrhagia, which continued off and on for over four months, finally ceased and menstruation became normal. It has continued so up to the present time now five months since recovery. The involution of the uterus is not as yet complete but the uterine cavity is contracted and more in keeping with the normal shape and size. During the early progress of the case the cavity was so large that it would have contained easily a medium-sized orange.

In this case the tendency to reformation of granular tissue was more marked than I ever witnessed. In some of its aspects the proliferation of neoplasms resembled a malignant degeneration, but this idea was dismissed and the theory of syphilitic influence was accepted as in full accord with the history of the case.

The explanation seems to be this, Under the influence of specific disease the placenta and decidua were primarily involved and separation took place, which resulted in the miscarriage of pregnancy and the removal of the fetus and secundines. The decidual membrane remained behind involved in

syphilitic disease and, in its exfoliation, continued to develop neoplastic tissue. The process of degeneration thus established was continued under the influence of the syphilitic virus. As fast as one set of neoplasms was removed a new set came on to take its place, thus containing the pathological state of the endometrium. I am convinced the influence of iodide of potash was a potent factor in the treatment of this case. This was shown on several occasions. It became necessary several times to discontinue the use of the drug in consequence of its effect upon digestion. During these intervals, whether from a bias in my own mind or actual fact, I was led to believe that haemorrhage was more severe and the recurrence of the neoplasms was more marked. I had never before witnessed a condition of the endometrium at all similar to that present in this case and, I have associated the influence of syphilis with the causation of the condition herein described. In my opinion a non-syphilitic endometrium would not behave in this manner. In cancerous disease a similar condition might be observed, but the recovery of my patient disproves this assumption, whilst her history gives strength to the syphilitic theory. Whilst this case was fresh in my mind a second

case came under my care which confirmed the view expressed above in regard to the influence of syphilis upon the endometrium. The extent of the involvement was neither so great nor so intractable as in the case of Mrs. A., but the history of the patient clearly points to a syphilitic influence extending through a series of years and secondarily involving the endometrium after a lapse of some three years.

Mrs. B., aged 27, primipara, was married six years ago. Some six months after marriage she became pregnant and about the sixth month of utero-gestation she miscarried without any assignable cause referable to objective conditions. Subinvolution, menorrhagia and metrorrhagia followed in the wake of the mishap, and for many months the health of this lady was greatly depreciated.

She was treated both locally and constitutionally by several physicians with the result that haemorrhage ceased, but subinvolution remained. Her husband, a gentleman of considerable intelligence, had contracted syphilis some time prior to marriage, for which he had been treated with what he presumed to be entire success. Believing himself cured he entered into matrimony only to find the germs of the disease aroused into

new activity by the new state. He almost immediately inoculated Mrs. B. with the poison, which became manifest in constitutional disturbance as well as in the local influence upon gestation. Following the miscarriage, which was the first explosive effect of the syphilitic poison upon the part of latter, both husband and wife were placed under syphilitic treatment by a physician in New York City, to whom they both applied. The wife was kept in ignorance of the nature of her disease, and, of course, that of her husband, and this ignorance now holds. The successive years of struggle with syphilitic manifestations by husband and wife I shall not discuss here, but the history is not an uninstructive one. Outward manifestations were so successfully combatted with anti-specific remedies that a complete check was placed on these. With the exception of sore throat, slight loss of hair and rheumatic pains, the husband has escaped. The wife continued to bear the legacy of an interrupted gestation in the shape of an entailed uterine disease. With the exception of back-ache, pelvic pain, leucorrhœa and general debility, no symptoms had occurred during the past three years referable to the uterus until six months ago. She had never conceived during this time.

About May last, without any exciting cause, uterine haemorrhage became profuse at the period, and during the intermenstrual period there was a free loss of blood lasting over two or three days. Menorrhagia and metrorrhagia were both established. This condition continuing, in spite of the use of ergot and other ecbolic agents, the husband became alarmed, brought his wife to this city and placed her under my care. Upon examination the uterus was found to be unusually large, flabby and relaxed. The probe easily entered three and a half inches. The cavity was open and distensible, readily admitting of the free rotation of the sound. The cervix was patulous and eroded, the edges gaping from an old bilateral laceration. The mucous membrane of the cervix and body was highly granular, and bled profusely the moment it was touched. The introduction of the curette brought away large masses of epithelium and fungous vegetations, which clearly accounted for the free flow of blood. Haemorrhage stopped the moment the curetting ceased; in fact before it was complete, for the uterus contracted so firmly under this stimulus that the blood supply was immediately cut off. Within less than a week's time there was a return of haem-

orrhage and the highly vascular condition of the endometrium re-appeared. The curette was again introduced and again a mass of epithelial tissue and vegetations was removed. Under this second curetting haemorrhage again ceased and notwithstanding the fact that daily applications of tannin and glycerine, and iodoform were made to the entire endometrium, the tendency to reformation of the vegetations went on, and curetting again became necessary. These neoplasms were again removed in less quantity than in the first instance. Local applications were made to the uterine cavity during the three subsequent weeks before the mucous membrane assumed an approximate normal condition. Iodide of potash was given in 15 grain doses *ter die* during the entire period and I have reason to believe its influence was direct.

I am unable to account for the condition of the endometrium observed in this case save on the ground of a syphilitic influence. Would a non-specific endometritis behave in this way? I confess my own experience has never presented a case at all similar. Whilst I have frequently met with granular conditions of the endometrium following miscarriages, and in the non-gravid state, they have almost invariably responded

to treatment when first instituted and have shown no such tendency to continued reformation of neoplasms as in the two instances cited. The knowledge of a syphilitic history in these cases induces me to refer the influence to the disease in question, and leads me to formulate the law that in all cases of obstinate and persistent endometrial involvement the condition of a syphilitic influence should be questioned.

I cannot but believe that the assumption of a specific influence as an etiological factor in obstinate conditions of endometrial disease may lead to the employment of constitutional treatment, *pari passu* with the local, which may secure results at variance with our expectations. It is well-known that many women have specific disease of which they are wholly ignorant, and we may readily suppose that in a certain number of this class the influence of the specific poison may manifest itself in an impression upon the endometrium either through repeated miscarriages, through catarrhal states inducing, it may be, sterility, or in conditions allied to those described in the cases herein related. I have no desire to exaggerate the importance of a syphilitic influence as an etiological factor in uterine disease, but I deem the facts presented of sufficient

interest and value to arrest attention and to invite a more careful consideration of this subject than it seems to me to have received. If others have noted this condition and will throw greater light upon the same than has been attempted in this brief communication the author will be deeply interested in their contributions.

